



OFFENDER I.D. DATA: (name)

(DOC#, birthdate)

(SSN)

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION BY NEXT OF KIN

(Only to be used if patient is incapacitated, deceased, or when otherwise authorized per RCW 70.02.140 and/or RCW 7.70.065)

I, \_\_\_\_\_, next of kin of the above named offender, hereby authorize the use or disclosure of my \_\_\_\_\_'s health information as described below.

PATIENT'S RELATIONSHIP TO SIGNATORY

The following individual or organization is authorized to make the disclosure:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The type and date(s) of information to be used or disclosed is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Purpose for disclosure: \_\_\_\_\_

I understand that the information in the health record may include information relating to sexually transmitted infections, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ (if left blank, authorization will expire six (6) months from signing).

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524 and RCW 70.02. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal or state confidentiality rules. If I have questions about disclosure of the health information, I may contact the RHIT/designee of the facility: \_\_\_\_\_.

\_\_\_\_\_  
Signature of Authorized Next of Kin  
(Do not sign if form is not complete)

\_\_\_\_\_  
Date  
(Next of Kin to complete)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

*State law (RCW 70.02; RCW 70.24.105; RCW 71.05.390) and/or federal regulations (42 CFR Part 2; 45 CFR Part 164) prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.*